| DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION  | FORM APPROVED<br>OMB NO. 0938-0193   |
|---|--|
|   | 1. TRANSMITTAL NUMBER: 2. STATE:   |
| TRANSMITTAL AND NOTICE OF APPROVAL OF   | 2001 <u>1 5</u> MS   |
| STATE PLAN MATERIAL HEALTH CARE FINANCING ADMINISTRATION  | 3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)   |
| TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION   | 4. PROPOSED EFFECTIVE DATE   |
| DEPARTMENT OF HEALTH AND HUMAN SERVICES   | July 1, 2001   |
| 5. TYPE OF PLAN MATERIAL (Check One):   |  |
| □ NEW STATE PLAN □ AMENDMENT TO BE CONSIDERED AS NEW PLAN △ AMENDMENT   |  |
| COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)   |  |
| 6. FEDERAL STATUTE/REGULATION CITATION:   | 7. FEDERAL BUDGET IMPACT:  a. FFY 2001 \$ -0-  b. FFY 2002 \$ -0-  |
| 433.139(£)(3) 3.50Pk 46352<br>8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:   | b. FFY 2002 \$ -0-  9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION  |
| o. The Nombert of The Least Section Strat (Assumett).   | OR ATTACHMENT (If Applicable):   |
| Att. 4.22-3 Page 1  | Att. 4.22-8 Page 1   |
| 10. SUBJECT OF AMENDMENT: In is State Plan Amendment changes the drug recovery for Third Party Secoveries from Comments to matchly and changes the threshold used for pharmacy claimes from TUC to TUC.  VERNOR'S REVIEW (Check One):  GOVERNOR'S OFFICE REPORTED NO COMMENT  COMMENTS OF GOVERNOR'S OFFICE ENCLOSED  NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL |  |
| 12. SIGNATURE OF STATE AGENCY OFFICIAL: 16.   | . RETURN TO:   |
|   | a Lewis-Payton, Executive Director   |
| 13. TYPED NAME:   | ision of Medicaid  |
|   | n: Kese Comp <b>e</b> re   |
|   | North Lamar Street, Suite Sui<br>Rson, MS 39201-1399   |
| 15. DATE SUBMITTED:   |  |
| June 27, 2001   |  |
| FOR REGIONAL OFFIC<br>12 DATE RECEIVED: 18<br>18 29 2081  | DATE APPROVED  |
| P AN APPROVED ONE   | TO SELVATORIES CONTRACTOR CONTRAC |
| TO EFFECTIVE DATE OF APPROVED MATERIAL: 20  | L SIGNATURE OF RESIGNAL OFFICIALS  |
| Jely 1, 2001<br>21 TYPEO NAME:  |  |
|   | TOT Annalus Regions Asimistrator   |
| STREMARKS:  | Titles of Medicald and State Contactions   |
| SE REMAYOU.   | the contract the transmission of substitution and the substitution of the substitution |
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Revision:

HCFA-PM-90-2

January, 1990

ATTACHMENT:

4.22-B

Page 1\*

OMB NO. 0938 - 0193

DRAFT

## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Mississippi

## Requirements for Third Party Liability-Payment of Claims

Citation (1) 433.139(b)(3) (ii)(c) 55 FR 1423 The provider is not required to file with the third party prior to filing Medicaid in a situation where the TP is derived from a parent whose obligation to pay support is being enforced by the State Title IV-D Agency.

433.139(f)(2) (2) 50 FR 46652 A threshold amount of \$100 is used to determine whether to seek recovery from a liable third party except for trauma-related claims in which case a threshold amount of \$250 is used.

433.139(f)(3) (3) 50 FR 46652 Pursuant to the waiver received from HCFA, Region IV, all pharmacy claims will be accumulated on a monthly basis for filing with the third party. A \$0 threshold will be used.

Third party recovery will be pursued when the accumulated monthly trauma code paid claims amount for each beneficiary equals or exceeds a \$250 threshold.

The MMIS will generate monthly invoices of prenatal, preventive pediatrics, and IV-D related claims when the accumulated paid claims for each beneficiary with a third party indicator in the claims payment system and no third party amount listed on the claim, equals or exceeds a \$100 threshold.

TN. NO. 2001 - 15

Supersedes
TN. NO. 91-31

Approval Date UIL 2 0 2001

Effective Date JUL 0 1: 2001